Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 14, 2014	2014_301561_0013	H-000130-14	Resident Quality Inspection

Licensee/Titulaire de permis

DELCARE LTC INC.
4800 DUFFERIN STREET, TORONTO, ON, M3H-5S9

Long-Term Care Home/Foyer de soins de longue durée

CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens, MISSISSAUGA, ON, L5A-4N8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DARIA TRZOS (561), DIANNE BARSEVICH (581), LALEH NEWELL (147), VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 23, 24, 25 and 26, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI Co-ordinator, Physician, Registered Staff, Personal Support Workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed meal services, observed the provision of care and services, and reviewed documents including but not limited to: clinical health records, policies and procedures, menus and meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident in relation to the following:

A. Resident #104's plan of care indicated that the resident can brush their own teeth. The Personal Support Worker (PSW) stated that the resident does not have their own teeth and only has dentures. The Registered Practical Nurse (RPN) confirmed that the resident has dentures and the plan of care did not provide clear direction to staff to provide denture care for the resident.

B. The plan of care for resident #110 indicated that they can start to brush their teeth but they get tired easily. Personal Support Worker (PSW) stated that the resident only has four teeth on the bottom, wears a partial denture on the bottom and full denture on the top. The Registered Practical Nurse (RPN) confirmed that the resident has both dentures and teeth and the plan of care did not provide clear direction to staff to include denture care. (581) [s. 6. (1) (c)]

2. The licensee did not ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change.

Review of the home's policy and procedure titled – Continence Care – Policy No: LTCE-CNS-B-05 stated that the home is to assess resident's continence care at time of admission and quarterly thereafter at a minimum for both urinary and bowel continence. Quarterly continence assessments will be based on resident's continence status deemed by the recording of the daily care record and where there is a significant change status, the resident's continence care needs will be reassessed using the Minimum Data Set (MDS) 2.0 assessment as a component of the comprehensive resident assessment.

A. Resident #112 was admitted in July 2013, review of the resident's electronic and clinical record and interview with the Assistant Director of Care (ADOC) confirmed that there were no continence assessment related to the resident's urinary and bowel continence completed at the time of admission. Further review of the resident's RAI-MDS for the past three quarters indicated that the resident was reassessed as having had a deterioration in urinary incontinence in March 2014, however, interview with the ADOC and the review of the resident's clinical record indicated that a quarterly continence assessment was not completed when a significant change in status was identified and the resident's care needs had changed. The plan of care was not reviewed and revised to reflect the resident's current care needs.

B. Review of resident #104's RAI-MDS for the past three quarters indicated that the resident was reassessed as having had a deterioration in urinary incontinence in November 2013, however interview with the ADOC and the review of the resident's clinical record indicated that a quarterly continence assessment was not completed when a significant change in status was identified and the resident's care needs had changed. The plan of care was not reviewed and revised to reflect the resident's current care needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change and to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licence was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system.
Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the ARD of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii)
Any significant change in resident's condition, either decline or improvement, shall be reassessed along with RAPs by the interdisciplinary care team using the MDS Full Assessment by the 14th day following the determination that a significant change in status has occurred.
Criteria for determining a significant change in status is identified in the Resident Assessment Instrument (RAI) MDS 2.0 and RAPs Canadian Version User's Manual, Second Edition, March 2005, pp 3-7, 3-8, 3-9. A "significant change" is defined as a major change in the resident's health status that:

• Is not self-limiting
• Impacts on more than one area of the resident's health status; and
• Required interdisciplinary review and/or revision of the care plan.

The licensee did not comply with the conditions to which the licence was subject.

A. The home did not meet the criteria for determining a significant change in the status of the following residents which required an interdisciplinary review and or/revision of the care plan:

i. Review of resident #201's RAI-MDS for (March 27, January 2, 2014, October 10, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. The resident's clinical chart was reviewed and interview with the registered staff confirmed that there were no physician's orders, diagnosis or reassessments completed to deem the resident as end stage disease. The physician confirmed that the resident was not end stage disease with six months or less to live.

ii. Review of resident #202's RAI-MDS for the past four quarters (March 27, January 2, 2014, October 17, July 25, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. Reviewed the resident's clinical chart which included diagnosis, assessments, physician's notes and orders and interview with the registered staff confirmed that there were no physician's orders, diagnosis or reassessments completed to deem the resident as end stage disease. The physician confirmed that the resident was not end stage disease with six months or less to live.

iii. Review of resident #203's RAI-MDS for the past four quarters (June 12, March 13, 2014, December 26, October 3, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, with six months or less to live. However, review of the resident's clinical chart and interview with the registered staff confirmed that the resident did not have a diagnosis, reassessments or an order from the physician to deem the resident as end stage disease. The physician confirmed that the resident was not end stage disease with six months or less to live.

iv. Review of resident #110's RAI-MDS for (March 6, 2014, December 12, September 26, July 4, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, with six months or less to live. Reviewed the resident's clinical

chart and interview with the registered staff confirmed there were no orders, diagnosis or reassessments to deem the resident as end stage disease. The physician confirmed that the resident was not end stage disease with six months or less to live

v. Review of resident #204's RAI-MDS for (December 12, September 19, June 27, April 11, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of the resident's clinical chart and interview with the registered staff confirmed that the resident did not have a diagnosis, an order or completed reassessments to deem the resident as end stage disease. The physician confirmed that the resident was not end stage disease with six months or less to live.

vi. Review of resident #205's RAI-MDS for (December 19, September 26, July 4, April 18, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of the resident's clinical chart, physician's notes, orders and interview with the registered staff confirmed that there were no reassessments, physician orders or diagnosis to deem the resident as end stage disease. The physician confirmed that the resident was not end stage disease with less than six months or less to live. (581)

vii. Review of resident #401's RAI-MDS for the past 5 quarters (May 29, February 27, 2014, December 12, September 19, and June 27, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of resident's progress notes, physician notes and interview with registered staff confirmed that the resident did not have a diagnosis of an end stage disease or an order from the physician to deem the resident as end stage with less than six months to live.

viii. Review of resident #402's RAI-MDS for the past 7 quarters (April 3, January 16, 2014, October 31, August 8, May 16, February 28, 2013 and December 6, 2012) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of resident's progress notes, physician notes and interview with registered staff confirmed that the resident did not have a diagnosis of an end stage or an order from the physician to deem the resident as end stage with less than six months to live.

ix. Review of resident #403's RAI-MDS for the past 8 quarters (June 5, March 6, 2014, December 12, September 19, June 27, April 4, January 10, 2013 and October 18,

2012) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of resident's progress notes, physician notes and interview with registered staff confirmed that the resident did not have a diagnosis of end stage or an order from the physician to deem the resident as end stage with less than six months to live.

x. Review of resident #400's RAI-MDS for 5 quarters (January 16, 2014, October 24, August 1, May 9, and February 14, 2013) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of resident's progress notes, physician notes and interview with registered staff confirmed that the resident did not have a diagnosis of end stage or an order from the physician to deem the resident as end stage with less than six months to live. (561)

xi. Review of resident #501's RAI-MDS for August 15, 2013, November 7, 2013, and January 23, 2014 indicated that the resident was coded under J5 of the RAI-MDS as end stage with less than six months to live. However, review of the resident's physician's progress notes, the most recent physician assessment April 22, 2014 (marked complete), and interview with the registered staff confirmed that there were no reassessments or physician's orders to deem the resident as end stage with less than six months to live.

xii. Review of resident #502's RAI-MDS for August 1, 2013, October 24, 2013, and January 9, 2014 indicated that the resident was coded under J5 of the RAI-MDS as end stage with less than six months to live. However, review of the resident's physician's progress notes, the most recent physician assessment January 7, 2014 (marked complete), and interview with the registered staff confirmed that there were no reassessments or physician's orders to deem the resident as end stage with less than six months to live.

xiii. Review of resident #503's RAI-MDS for October 3, 2013, December 26, 2013 and March 20, 2014 indicated that the resident was coded under J5 of the RAI-MDS as end stage with less than six months to live. However, review of the resident's physician's progress notes, the most recent physician assessment April 1, 2014 (in progress), and interview with the registered staff confirmed that there were no reassessments or physician's orders to deem the resident as end stage with less than six months to live.

xiv. Review of resident #504's RAI-MDS for December 19, 2013 and March 13, 2014

indicated that the resident was coded under J5 of the RAI-MDS as end stage with less than six months to live. However, review of the resident's physician's progress notes, the most recent physician assessment April 1, 2014 (in progress), and interview with the registered staff confirmed that there were no reassessments or physician's orders to deem the resident as end of life with less than six months to live.

xv. Review of resident #505's RAI-MDS for September 12, 2013, December 5, 2013, and February, 2014 indicated that the resident was coded under J5 of the RAI-MDS as end stage with less than six months to live. However, review of the resident's physician's progress notes, the most recent physician assessment April 1, 2014 (in progress), and interview with the registered staff confirmed that there were no reassessments or physician's orders to deem the resident as end stage with less than six months to live.

xvi. Review of resident #506's RAI-MDS for October 10, 2013, January 2, 2014 and March 27, 2014 indicated that the resident was coded under J5 of the RAI-MDS as end stage with less than six months to live. However, review of the resident's physician's progress notes, the most recent physician assessment January 7, 2014 (complete), and interview with the registered staff confirmed that there were no reassessments or physician's orders to deem the resident as end stage with less than six months to live. (539)

xvii. Review of resident #301's RAI-MDS (Resident Assessment Instrument - Minimum Data Set) for the past four quarters (August 22, November 14, 2013, February 6 and May 8, 2014) indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of the resident's clinical chart and interview with the registered staff, DOC and the RAI coordinator confirmed that the resident did not have a diagnosis of an end stage disease or an order from the physician to deem the resident as end stage with less than six months to live.

xviii. Review of resident #302's RAI-MDS for October 17, 2013 indicated that the resident was coded under J5 of the RAI-MDS as end stage disease, six months or less to live. However, review of the resident's clinical chart, physician's orders and interview with the registered staff confirmed that there were no reassessments or physician's orders to deem the resident as end stage with less than six months to live. [s. 101. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee shall comply with the conditions to which the licence is subject., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program.

During lunch meal service a Personal Support Worker was observed feeding residents. The Personal Support Worker then went and served desserts to another table of residents, proceeded to clear dirty dishes from another table and then returned to assist with feeding of another resident. The Personal Support Worker completed these tasks without washing or sanitizing their hands between the resident interactions.

During lunch meal service on another floor a Personal Support Worker was observed feeding a resident. The Personal Support Worker then went and assisted another resident with mobility and inserted a head phone into the resident's ear. She returned to assist with feeding of the resident. The Personal Support Worker completed these tasks without washing or sanitizing their hands between the resident interactions.

The home's policy for Infection Prevention: Hand Hygiene, Policy No: LTCE-INF-B-04, effective February, 2007 and revised March, 2008 and August, 2012, stated that Hand Hygiene is to be performed "before preparing, handling serving or eating food" and "after resident or resident environment contact". The Administrator confirmed it would be the expectation of the home that hand hygiene be performed in accordance to the policy in the instances above. [s. 229. (4)]

Issued on this 8th day of August, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs